AUTHORIZATION FOR
Comprehensive MedPsych Systems
TO RELEASE/OBTAIN PATIENT INFORMATION

Patient Name: ____ DOB: ______________________

Address: ______________________________ City: _______________________ State: _____ Zip: _________

Best Phone #: __________________________ Email: ______________________________________

I hereby give the Medical Records Dept at: **Comprehensive MedPsych Systems, Corp Office**
1090 South Tamiami Trail
Sarasota, Florida 34236
Ph: (941) 363-0878 Fax: 716-242-3360 Email: lisagolden@medpsych.net

Permission to release information ☐ TO OR Request Information ☐ FROM the following; OR ☐ Send to Myself

Name: ____

Address: ____ City ________________ State _____ Zip __________

Phone: ________________________ Fax: _____________________ Email: ______________________________

Please initial: _____ **I hereby give permission to release or have the following documents given to the above named person:**

- ____ **All Mental Health Notes / Information**
- ____ Initial Intake – History and Physical
- ____ Psychiatry Notes (my provider's name is _____________)
- ____ Psychotherapy Notes (my provider's name is _____________)
- ____ Neuropsychological/Psychological Testing Report
- ____ Testing Raw Data (may release only to another psychologist)
- ____ Verbal Communication Only
- ____ Treatment Summary Only
- ____ Lab Work
- ____ Billing Statement
- ____ Dates of Service Only
- ____ Other _______________________

For the purpose of:

____

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Please initial: _____ I acknowledge, and hereby consent to such, that the protected health information (PHI) released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I also acknowledge that I have read the information below and authorize the disclosure of the protected health information (PHI) as stated.

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. However, we may refuse to provide you access to certain notes, reports, testing raw data, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative legal/forensic proceedings or for other reasons in accordance with state, federal, workers compensation and/or HIPAA law.
6. I may receive a copy of this form after I sign it.

Signature of Patient / Patient's Representative: ______________________________________ Date: ___________

Print Name of Patient / Patient's Representative: ______________________________________

If Patient's Representative, what is the relationship: ______________________________________

ID Verified by: _________ (CMPS staff initials)

Note: This authorization will expire one year from the date signed.